

## Russian Medical Care in the 1990s: A User's Perspective

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### **Abstract:**

This article examines medical utilization patterns and attitudes toward the medical care system among the citizens of Russia's second largest city, St. Petersburg. It focuses upon the extent to which both attitudes towards and usage of medical care institutions have changed in the immediate post-Soviet period. A particular concern has been to determine the degree to which utilization and perceptions vary across the socioeconomic status hierarchy. The data were collected in two stages: a mass survey ( $N = 1500$ ) conducted in mid 1992 and intensive follow-up interviews ( $N = 44$ ) conducted in late 1994. The findings indicate that urban Russians were very critical of their medical care system at the end of the Soviet period. Most feel that the system has deteriorated even further since the end of 1991, and they are particularly worried about the emergency care system and about hospital conditions. Although people believe that the system now includes more alternatives, very few have changed their medical utilization patterns to take advantage of these new possibilities. This is more a product of their perceived high cost than of principled opposition to "pay" medicine. The analysis also demonstrates the extent to which medical utilization differs by socioeconomic status. Lower status individuals tend to utilize the formal medical care system. High status individuals seek help from a variety of sources and, in particular, rely much more heavily on informal connections to the medical care system. The medical help-seeking strategies of higher status groups have proven to be reasonably adaptable to the post-Soviet medical marketplace, while for others finding good quality medical care remains more problematic.

**Key words:** Russian medical care, medical utilization, health attitudes, socioeconomic status

### **INTRODUCTION**

This paper examines recent developments in the medical care system of Russia, focusing on how the system is perceived by the ordinary Russian citizens who utilized the medical system before the Soviet Union ceased to exist in late 1991 and who continue to utilize it now. The data for this analysis were collected in St. Petersburg, Russia, between 1992 and 1995. While the attitudes and experiences of *Peterburgtsy* may not typify those of all Russians, it is our contention that examining the perspectives of an urban population which has traditionally been provided with better than average medical care is an important step in understanding how the population as a whole is responding to the current situation.

Both the professional and the popular press in recent years have chronicled in agonizing detail the predicament of the medical care system in post-Soviet Russia. The writers have painted a dismal picture of declining utilization of medical services despite rising morbidity and mortality, the resurgence of deadly infectious diseases such as diphtheria and tuberculosis, widespread hepatitis, as well as deteriorating physical structures, broken equipment, shortages of medical supplies, and limited access to medications which have either completely disappeared from pharmacy shelves or are offered for sale at prices which much of the population can ill afford to pay (Bohlen, 1993; Feshbach and Friendly, 1992; Field, 1994, 1995; Hockstader, 1994).

Most analyses of health conditions in the Russian Federation have been based upon macro level data on morbidity, mortality, and the availability of resources within the medical system (Mezentseva and

Rimachevskaya, 1992; Watson, 1995). There have also been investigations of the efforts to transform medical care from a centrally planned and financed system to a more pluralistic insurance-based system (Curtis *et al.*, 1995; Sheiman, 1994; Telyukov, 1991). A few survey researchers have reported on the dissatisfaction of the Russian population with its medical care (Meditsinskaya Gazeta, 1992; Telyukov, 1991).

The research reported here offers further insight into popular attitudes and behaviors. Our data, both quantitative and qualitative, provide an in-depth look at the way in which ordinary people use the medical system and at their perceptions about changes in its functioning. The analysis also focuses on the extent to which both utilization and perceptions vary across the socioeconomic hierarchy. In addition, we analyze people's feelings about the ability of the medical system to solve their health problems, attitudes toward and experiences with "pay medicine" (*platnaia meditsina*), and the extent to which recent developments have led them to change their strategies for gaining access to medical care providers and institutions.

## METHODOLOGY

This research is part of a larger project which examines relationships between socioeconomic status and health in the adult population of St. Petersburg. The data were collected in two stages. The first phase consisted of a mass survey which was conducted in May and June of 1992, just a few months after the dissolution of the Soviet Union. Interviews were carried out with a stratified random sample ( $N = 1500$ ) of the adult population (ages 18 and over) living within the historic boundaries of the city. The sampling procedure involved a complex multistage selection process utilizing a combination of telephone and housing records and was based upon region of residence and random selection. At different stages of sample construction each of the following was controlled: type of residence (individual vs communal apartment), residence zone, and the basic sociodemographic parameters of age and gender.

The survey contained largely closed-ended questions about a wide range of health-related issues. We asked questions designed to assess subjective health status, lifestyle, personal and family health behavior, attitudes toward health and illness (health culture), and the role of informal networks (lay and professional) in medical help-seeking. Other questions focused on utilization of and attitudes toward the medical care system (including cooperative medicine, private physicians, and alternative healers as well as governmental institutions and practitioners).

The second phase of the data collection entailed intensive follow-up interviews (two to three hours) with a small subset ( $N = 44$ ) of the original sample. These interviews were conducted in the late fall of 1994. The individuals chosen for these follow-up interviews were randomly selected (controlling for age, gender, and place of birth) from each of the six socioeconomic groups we had identified in the larger sample. Our intention was to interview a total of eight individuals in each socioeconomic group (four male and four female) who had been between the ages of 35 and 45 at the time of the original survey. For the most part we were successful; however, despite intensive efforts, we were unable to locate any of the men in Group VI (see below), an indication of the social marginality of this group. We elected to interview individuals in this particular age cohort because they were old enough to have accumulated significant medical histories, yet they were all born after World War II.\* Furthermore, individuals in this age group tend to interact broadly with the medical care system: they are old enough to have begun to experience those health problems which emerge in the middle years of life, yet they are often still dealing with the health problems of children. Many are helping to provide for the medical care needs of aging and ailing parents as well.

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\* For the purposes of this analysis we elected to interview only individuals who were born after World War II. The war time experiences of the Soviet citizenry varied enormously. This is particularly true of the current population of Leningrad, due to the lengthy blockade of the city. Inclusion of older individuals would have significantly complicated our efforts to analyze health inequalities. We are currently planning a new project in which we will interview much older men and women.

The goal of these follow-up interviews was to probe in greater depth with our respondents their attitudes about health, illness, and medical treatment in general and their own health status in particular, and to gauge the extent to which their health, lifestyles, medical utilization patterns, and attitudes had changed in the two and a half years since the original survey. We also asked respondents to describe in detail their lifestyles as children and as adults. A particular focus in these discussions was to ascertain the extent to which individuals from different levels in the social hierarchy have had access to formal and informal sources of help both in meeting their health care needs and in maintaining their preferred lifestyle patterns.

We used educational attainment as the principal indicator of socioeconomic status. Our classification of the population into socioeconomic groups took into account not only the educational attainment of the respondents but that of their parents as well. We used this two-generation approach because of strong evidence that early life experiences have long-lasting and significant effects (both direct and indirect) not only on health status but on health-related attitudes and behaviors as well.

Using this two-generation educational attainment criterion we identified six socioeconomic groups in the population of St. Petersburg: an "Established Intelligentsia" (Group I), respondents with some higher education and at least one parent with some higher education; a "New Intelligentsia" (Group II), respondents with some higher education whose parents have completed at most a secondary education; a "Downwardly Mobile" category (Group III), respondents who have completed secondary education but who have at least one parent with some higher education; a "Stable Skilled" category (Group IV), respondents who have completed secondary education and whose parents have also completed secondary education; a "Newly Skilled" category (Group V), respondents who have completed secondary education and whose parents have completed less than secondary education; and an "Unskilled" category (Group VI), respondents who have completed less than a secondary education and whose parents have a similar educational background.

Table 1. Socioeconomic status groups<sup>a</sup>

	Description	Educational attainment		N	%
		Respondent	Parents		
Group I	Established Intelligentsia	Higher	Higher	278	18.9
Group II	New Intelligentsia	Higher	Secondary or less	338	22.5
Group III	Downwardly Mobile	Secondary or less	Higher	143	9.7
Group IV	Stable Skilled	Complete secondary	Complete secondary	279	18.9
	Newly Skilled	Complete secondary	Less than complete secondary	325	22.1
Group V					
	Unskilled	Less than complete secondary	Less than complete secondary	110	7.5
Group VI					
	Totals			1473	100

<sup>a</sup>St. Petersburg, Russia, 1992.

Three of these groups (Groups I, IV, and VI) are characterized by intergenerational social stability, i.e. similarity in educational attainment; two of them (Groups II and V) have experienced intergenerational upward educational mobility; and one group (Group III) is characterized by intergenerational downward educational mobility (see Table 1). Only 27 of our original respondents were excluded from the analysis by this methodology, that is, they did not fall into any of the aforementioned socioeconomic groups. These were mostly individuals for whom we had no information about either parent.

## ANALYSIS OF FINDINGS

### *Attitudes toward the medical care system in 1992*

Our survey of attitudes shortly after the dissolution of the Soviet Union revealed that the citizens of St. Petersburg were extremely critical of their medical care system, and most believed it to be in need of fundamental restructuring. Over 88% of our respondents answered positively when asked if the system needed "radical reform". These critical attitudes were quite consistent across the population, i.e. they did not differ significantly by gender or by socioeconomic status. Even the elderly, who tended to judge the system somewhat less harshly, mostly advocated radical reform (72% of those over the age of 60 years).

People were particularly displeased at the performance of the two principal components of the Soviet medical care system: polyclinics and hospitals. Only a small minority described the care provided by these institutions as "good": 7.5% for polyclinics and 6.5% for hospitals. By contrast, nearly two-thirds characterized the quality of care as "poor": 60.9% described polyclinics in this way, and the percentage was even higher for hospitals (63.5%).

There was also significant agreement about what needed to be improved. Of greatest concern to our respondents was the limited availability of modern medical equipment and medications. More than three out of four mentioned the need for better equipment in both polyclinics (78.2%) and hospitals (76.3%), and almost two-thirds (65.1%) stated that hospitals needed to be better supplied with medications.

There was also widespread dissatisfaction with the quality of medical personnel. The concern focused on physicians rather than ancillary personnel (such as nurses or aides), and it was especially evident with respect to polyclinics. Overall, two-thirds (67.2%) of our respondents said that the qualifications of polyclinic physicians should be improved, and two in five (39.7%) regarded this as the most important change that should be made to the polyclinic system. The level of apprehension was clearly linked to socioeconomic status. Among the Established Intelligentsia (Group I) an impressive 77% expressed concern about the competence of polyclinic physicians, and almost half (48.4%) regarded this as the single most important problem facing polyclinics. Members of the Unskilled category (Group VI), on the other hand, were less likely to focus on the adequacy of medical expertise. Although slightly more than half of the members of this group (55.5%) mentioned the need to improve polyclinic physician skills, far fewer (26.3%) regarded this problem as the most important one. By contrast Group VI members were far more likely than higher status individuals to say that polyclinics needed to expand the availability of home care (17.2% vs 5.5% in Group I) and that efforts should be expended to make the polyclinic a more pleasant place to be. Slightly more than 14% (14.1%) of the Unskilled mentioned polyclinic ambience as a significant problem, whereas only 5.5% of the Established Intelligentsia expressed that concern.

Medical consumers in St. Petersburg were also less than ecstatic about the competence of hospital physicians, although they were more worried about the adequacy of medical equipment in those institutions. Nonetheless, 4-4.3% of the people in our sample felt that the qualifications of hospital physicians needed improvement, and almost a third (28.5%) regarded correcting this problem as the single most important thing to do to improve the quality of hospital care. In general, views about the inadequacies of the hospital system were more consistent across the population than opinions about polyclinics; however, the Established Intelligentsia were the most consistently critical of hospital physicians. Lower status individuals, on the other hand, were relatively more likely to mention the need to increase the number of non-professional workers (aides, cleaning staff, etc.) in hospitals (11.9% in Group VI compared with only 6.4% in Group I).

That members of the intelligentsia should be more critical of medical expertise than less educated individuals is not surprising. Data from many societies have confirmed the tendency of those with higher levels of education to be both more skeptical about medical authority and more discriminating consumers of medical care (Rosenthal and Frenkel, 1992). Higher levels of education seem to foster respect for professional knowledge (and for health) in general, while simultaneously making individuals more likely to question the competence of the individual professionals with whom they interact (Abbott, 1988; Freidson, 1989).

In the Soviet case this general trend may be especially pronounced because of the marked internal stratification of the medical profession into a low prestige, female dominated polyclinic sector and a higher prestige largely hospital-based stratum of medical specialists (Field, 1967; Ryan, 1990). Virtually everyone has some experience with the former. Many of these interactions are routine and involve minor health matters (e.g. receiving sick leave certification), and the polyclinic physicians have been chronically overworked, leaving them very little time for each individual patient. In short, these are not the kinds of encounters which tend to encourage either trust or the notion that the "expert" possesses esoteric and valuable knowledge which is inaccessible to the client. Furthermore, many of the polyclinic physicians in St. Petersburg are both first

generation intelligentsia and recent immigrants to the city (Rusinova and Brown, 1996). Each of these characteristics puts them at a distinct status disadvantage in their interactions with the members of the Established Intelligentsia.

The people of St. Petersburg in mid 1992 were not only extremely critical of the medical care system; they were also quite skeptical that the recent passage of a medical insurance law would improve the situation. In fact, more than one in three (67%) of our respondents was not even aware that such a law had been passed, and most of the rest did not expect it to have much effect. Only 12% believed that the medical care system would be significantly different as a consequence of this new legislation.

As they pondered the potential consequences of the introduction of a medical insurance system, most people (79.8%) expressed the belief that it would increase their medical costs. More than two in five (41.5%) said that they expected those costs to increase significantly; the remaining 38.3% anticipated only a moderate increase. These expectations were generally consistent across the socioeconomic hierarchy. The only exception was among the Unskilled, who were much less likely either to know about the planned reforms or to be able to anticipate how they might personally be affected by them. More than a third (33.7%) of this group had no idea what the economic impact of the reforms might be (by comparison with only 14% of the sample as a whole).

Opinions about the effects of the reforms on the quality of medical care were more equivocal. Many people (65.1%) professed not to know whether medical care would become better or worse after the reforms were implemented. In general, the Established Intelligentsia were the most optimistic about the likelihood of improvement (35.7% compared with 29.8% overall) and the Unskilled were the most equivocal (only 22% were willing to express an opinion one way or the other). The depth of dissatisfaction with the existing medical system is suggested by the fact that only five percent of our respondents indicated in 1992 that they believed that the new medical insurance law would produce a medical system worse than the one that was already in place.

#### *Utilization of medical services*

Despite the fact that *Peterburgtsy* have been highly critical of their medical care system, most of them use it with some degree of regularity. Our data indicate that there exists a "hard core" group of individuals who do their best to avoid seeking any medical care, but this group is small (9.5%) and for the most part young and in good health. The rest of the population does rely on the medical system; however, there are important differences in the utilization patterns of people at different levels of the socioeconomic hierarchy.

We focused our analysis on the utilization of outpatient medical services, as this is the point at which almost all individuals enter the medical care system. While the neighborhood polyclinics have traditionally been the central institution providing primary medical care, they have coexisted with a variety of other primary care providers. Some of these alternatives have been officially available for a long time; others were either perestroika era innovations or had previously functioned as part of a hidden informal marketplace of medical services, surfacing only as a result of *glasnost* and *perestroika* during the late 1980s.

Table 2. Where people go for medical help

		Usually or always (%)	On occasion (%)	Rarely or never (%)
1	Neighborhood polyclinic	54.1	20.6	24.1
2	Work place polyclinic	19.3	13.5	67.2
3	Physician friend	15.	18.2	66.7
4	Self-financing polyclinic	4.7	22.7	72.6
5	Medical cooperative	3.9	17	79.1
6	Private physician	3.7	7.2	89.1
7	Non-traditional healer	3.1	8.8	88.1

Note: Based on survey (N = 1473) of population of St. Petersburg, Russia, 1992.

The neighborhood polyclinic was in 1992 the most frequently used institution (see Table 2). Nonetheless, only slightly more than half (54. %) of our respondents reported that they almost always sought care at their local

polyclinic, and almost a quarter (24.1%) indicated that they rarely or never frequent that ubiquitous neighborhood institution. Propensity to rely on one's neighborhood polyclinic varies significantly by socioeconomic status, with lower status individuals relying much more heavily on it than others. Almost three-quarters (74.1%) of the Unskilled (Group VI) and two-thirds (67.7%) of the Newly Skilled (Group V) reported that they use the neighborhood polyclinic exclusively. By contrast fewer than half of the intelligentsia rely solely on neighborhood polyclinics (44.5% in Group I and 46.3% in Group II) (Table 3).

The second most commonly used institution is a polyclinic associated with place of employment. Our data are consistent with Soviet statistics which indicate that approximately 30% of the population has had access to health care in the work place (Hyde, 1974; Ryan, 1978). Approximately a third of our respondents (32.8%) indicated that they use a work place polyclinic at least occasionally. However, almost one in five (19.5%) reported that such a polyclinic is their principal source of primary medical care, and the individuals who rely on these institutions are the least likely to use their neighborhood polyclinic for any reason. In large part this is due to the fact that the work place polyclinics have the authority to certify sick leave, but our data also suggest that the people who have access to such institutions and use them regularly do so because they are reasonably satisfied with the quality of the care they receive. At minimum, there is a very strong positive correlation ( $P < 0.001$ ) between frequency of work place polyclinic usage and reported satisfaction with one's personal polyclinic care.

The frequency of work place polyclinic utilization also varies significantly with socioeconomic status.

Table 3. Variation in utilization patterns by socioeconomic status

Primary care providers	Group (%)					
	I	II	III	IV	V	VI
			<i>Neighborhood polyclinic</i>			
Usually	44.5	46.3	56.4	53.5	67.7	74.1
Never	32.0	31.1	25.7	20.3	17.7	9.3 <sup>b</sup>
			<i>Work place polyclinic</i>			
Usually	18.2	26.6	21.9	18.5	16.3	8.2
Never	64.4	57.4	62.5	69.9	74.0	82.7 <sup>b</sup>
			<i>Physician friend</i>			
Usually	27.5	14.8	18.2	13.6	8.7	1.0
Never	51.5	62.2	60.6	67.9	77.3	94.0 <sup>b</sup>
			<i>Self-financing polyclinic</i>			
Usually	5.7	6.8	5.3	3.0	3.7	1.0
Never	69.2	61.1	76.5	75.4	76.0	93.1 <sup>b</sup>
			<i>Private physician</i>			
Usually	5.1	4.3	4.6	3.1	3.4	1.0
Never	83.1	86.0	87.7	90.8	92.6	98.0 <sup>a</sup>
			<i>Medical cooperative</i>			
Usually	4.2	5.0	4.6	5.7	2.0	0
Never	76.4	75.9	74.6	75.8	83.9	94.1 <sup>a</sup>
			<i>Non-traditional healer</i>			
Usually	2.7	3.0	5.3	4.9	2.0	0
Never	87.4	84.9	86.3	87.5	91.0	95.0

<sup>a</sup> $P < 0.01$ , overall value of  $\chi^2$ .

<sup>b</sup> $P < 0.001$ , overall value of  $\chi^2$ .

Those who reported the most consistent use are the New Intelligentsia (Group II), of whom 26.6% indicated that they use a work place polyclinic almost exclusively. The lowest levels of utilization were reported by the Unskilled (Group VI: 8.2%) and the Newly Skilled (Group V: 16.3%).

These usage patterns are due in part to the fact that individuals with differing educational backgrounds tend to be employed in different sectors of the economy, and economic sectors have varied in the level and quality of benefits they offer their employees. Such perquisites have in general been more available to the intelligentsia and some skilled industrial workers. Our data indicate, however, that the Established Intelligentsia use work place polyclinics much less than the New Intelligentsia. Moreover, members of the Established Intelligentsia apparently rely less on work place medical care not because they have less access to it but because their overall strategies for choosing primary medical care providers are different.

The distinctive utilization pattern of the Established Intelligentsia is revealed by the extent to which its members rely on physicians who are friends (*znakomyi vrach*). As Table 2 indicates, physician friends are the third most common source of primary medical care. Not unexpectedly, access to this informal system of care varies greatly with socioeconomic status.

Overall, almost half of our respondents (45%) indicated that they know someone (a friend or relative) who works in the medical care system and is in a position to assist them with their medical care problems. The rates are much higher for the intelligentsia (58.3% among the Established Intelligentsia and 53.5% among the New Intelligentsia) than for other groups, particularly the Newly Skilled (38.7%) and the Unskilled (19.3%). Even more significantly, however, our data indicate that both the quantity and the quality of the assistance provided by these personal "connections" to the medical care system vary enormously.

The importance of informal social relationships in attaining access to goods and services which have been either in short supply or of unpredictable quality is a universally acknowledged feature of the Soviet economic system (Markowitz, 1991; Shlapentokh, 1989). Reliance upon the assistance of friends and family in dealing with health-related problems is no less common than in other spheres of life. Interviews we conducted with both lay people and physicians in the early 1990s indicated just how widespread and variegated is this informal economy in medical services.

People utilize this informal medical marketplace in order to receive direct physician services: medical consultations and medical procedures. They also rely on friends and relatives to help them identify and gain access to highly qualified medical personnel, to medical equipment and analyses, and to superior medical institutions. And, of course, friends and relatives assist in the often time-consuming task of finding needed medications and medical supplies. Some, but by no means all, of this activity involves exchanges of money.

The extent to which individuals can count on their informal "connections" to the medical system to solve complex problems varies with both the positions of those who comprise this help network and the network's density. In other words, the more "connections" one has and the higher the status of those "connections" in the medical hierarchy, the better and more comprehensive is the assistance they can provide. In the intensive interviews we conducted in late 1994, we asked our respondents to describe in some detail their own personal medical care networks as well as those of the families in which they grew up.

Only among the Established Intelligentsia and the Downwardly Mobile (Group III), all of whom had at least one parent with higher education, did a preponderance of respondents recall that utilizing "connections" had been a central component of their parents' strategies for meeting the medical care needs of their families. Furthermore, with only one exception, the "connections" described by these individuals were all physicians, and all were either relatives, close friends, or in one case, former students with whom the respondent's teacher parent had maintained close contact. Two other individuals from intelligentsia backgrounds described their families' strategies for attaining medical care when they were children as reflecting their parents' privileged positions in the Communist Party apparatus. In one case this had entitled the family to access to the closed system of medical care for elites in Leningrad; another woman reported that her parents' positions in another small city had entitled her to the best of everything her community had to offer ("all I had to do was mention my last name...").

The childhoods of individuals who did not grow up in intelligentsia families were typically characterized by much greater reliance on the formal system of medical care. "Connections" with physicians were uncommon. One member of the Stable Skilled (Group IV) reported that her aunt had worked as a school physician and that the family had sought her advice when someone fell ill. A member of the New Intelligentsia indicated that her family had had "connections", because her mother was a seamstress who had physician clients. However, as it turns out, these valued clients were in fact physicians at the family's neighborhood polyclinic, to whom they would have had ready formal access in any case.

Respondents from non-intelligentsia backgrounds did describe other types of "connections" to the medical system which their families had utilized when they were growing up. By far the most common were friends or relatives who either had specialized secondary medical educations (mostly nurses or pharmacists) or whose jobs gave them access to medical goods. Such persons could provide valuable assistance with a limited range of problems, such as finding medications which were in short supply. However, by comparison with the services which could be rendered by physician friends (e.g. referrals to highly qualified specialists and access to the better hospitals and institute clinics) their limitations are readily apparent.

Analysis of experiences over two generations clearly demonstrates the advantages which accrue to members of the Established Intelligentsia. Most of these individuals are able to retain the "connections" established during their childhoods and to augment them from their own adult social networks. Only one of our Group I respondents insisted that she has no informal ties to the medical care system, but this is an individual who reported that she seeks to avoid all physicians as much as possible. Others readily acknowledged their reliance upon friends and family. As one man, himself the son of a physician, commented, "Of course I have connections (sviazi)... My entire approach toward medical care is oriented around my circle of acquaintances". Another woman from this group insisted that having "connections" to the medical care system could mean the difference between life and death. Describing a recent medical care emergency involving a parent, she declared her conviction that the direct intervention of a member of her informal medical care network had proved invaluable: "my father is alive only because of {our} personal connections... If a person doesn't have an interested physician available in such instances, he simply won't survive".

By comparison, those who are Downwardly Mobile are at a disadvantage. The members of this group are somewhat more likely to be recent migrants to St. Petersburg, which means that the "connections" established by their parents are of limited value to them, and because they are not themselves members of the intelligentsia their friendship networks are less likely to include many physicians, especially highly placed ones. Nonetheless, the majority of the Downwardly Mobile individuals we interviewed have at least one physician friend or relative with whom they can consult, although many of these "connections" are somewhat tenuous. One man denied at first that his family has any informal ties to the medical care system, but then he corrected himself: "Well, there's the father of my wife's best friend. We can consult with him occasionally, but he's already retired". Another man described his relief when his daughter became a medical student and informed her parents that they would be able to get some medical care at her institute's clinic: "we've finally won our way [into the system]!"

Members of the New Intelligentsia do not have the social networks of parents to fall back upon. Our data indicate, however, that they make a concerted effort to develop their own informal medical "connections" as adults. While almost all succeed to some degree, their "connections" remain qualitatively different from those of the Established Intelligentsia.

With only one exception all of our New Intelligentsia respondents indicated that they utilize personal "connections" in the medical care system. One man is married to a physician, and a woman from this group described to us in detail how she had actively cultivated "connections" with a polyclinic physician with whom she had sensed some rapport. Another described her "connections" as consisting of a pharmacist sibling and several doctors with whom her husband had served on a naval expedition. The former lives in another town and travels to St. Petersburg once a year to bring her a supply of medications; the help of the latter is confined to filling out occasional health certificates (*spravki*) for her husband.

Whereas members of the Established Intelligentsia frequently enter medical care institutions under the "protection" of someone well-placed in the system, the New Intelligentsia are more likely to use their "connections" only to determine where it is possible to get good care. Having made that determination they subsequently walk through the door of the institutions unescorted. This may be one reason why the members of this group have been the most frequent users of the oldest "for pay" sector of the medical system, the self-financing (*khozraschetnaia*) polyclinics. Generally small in size and limited in scope the self-financing



polyclinics have existed in large urban areas since the mid 1920s. The main attraction of these polyclinics, according to one commentator, has been the strong reputation of their medical staffs, many of whom have advanced degrees and seniority. In short, these polyclinics offer "the opportunity to consult any of the well qualified doctors 'without red tape..." (Ryan, 1990, p. 96). To the New Intelligentsia, who share with their more established peers a belief in the importance of health, but are more restricted in those personal "connections" which facilitate acting upon that belief, the self-financing polyclinics apparently play an important role. At any rate, almost two out of five (39%) members of the New Intelligentsia report that they sometimes use these institutions (compared with 27% of the sample as a whole).

Lower down the socioeconomic hierarchy, "connections" to the medical care system are both less common and less effective. One Stable Skilled respondent described her informal medical care network as extensive and variegated (including several categories of medical specialists), but she is clearly exceptional. A striking contrast (and more typical example) is provided by a woman in this same group (Group IV), a former cancer patient, who described how she happened by sheer coincidence to be referred through the formal system to a prominent oncologist: "everyone was surprised that I hadn't used any "connections" (*blat*). None of the other patients in my room could believe that I got there {from a routine polyclinic referral}. Why was he treating me?" The "connections" described by other members of this group were for the most part individuals with specialized secondary educations rather than physicians.

The Newly Skilled (Group V) are even less likely to have access to personal "connections". Our informants mostly discussed their relationships with nurses and pharmacists, who provide advice and medications. However, even individuals with relatively low social status sometimes have physician friends. The relative infrequency of such episodes and the importance of "connections" with physicians when they do appear are suggested by the reaction of a Newly Skilled woman, who described with mild amusement what had happened when her daughter married a surgeon: "No sooner did he appear than suddenly everybody got sick with everything. Everyone threw themselves at him: "examine me!"

The least advantaged group in the population in terms of informal access to the medical system is clearly the Unskilled. Only one of the women we interviewed from this group reported any kind of personal "connection" to the medical care system. Her "connection" was a physician cousin with whom she has very little contact. She could envision herself utilizing that "connection" only in an extreme case: "if I needed some kind of operation, of course, I would arrange it through her".

For the most part the Unskilled rely on the formal medical care system, particularly the neighborhood polyclinic. Like individuals in both Skilled categories (Groups IV and V), the Unskilled reported that their principal criteria in choosing primary medical care are pragmatic: convenience, cost, and habit. (The intelligentsia, by contrast, were more likely to indicate that they make choices based on the reputations of specific physicians and medical institutions.)

The Unskilled also reported somewhat higher levels of satisfaction with the care they have received at neighborhood polyclinics (only 33.0% describe that care as "poor" compared with 44.6% of the Established Intelligentsia and 40.3% overall). Nonetheless, our interviews suggest that at least some of them would like to have more options. One woman from this group described her concerns about a particular medical procedure which she thought might be helpful to her, then commented almost wistfully: "if only I had a physician friend who knew about this... But I don't".

In addition to the primary care institutions which have already been discussed, a small proportion of the population seeks medical care from medical cooperatives, private physicians, and non-traditional healers. The medical cooperatives were introduced during the period of perestroika as alternatives to the centrally funded and controlled state medical care system. The cooperatives offer a wide range of services, most, but not all, of which overlap with those provided by the state sector. In addition to primary medical and dental care, for example, cooperatives provide services as diverse as "homeopathic medicine, private sanatoriums, and the care

of invalids" (Jones and Moskoff, 1991, p. 58). Individual private physician practice, by contrast, was an ever-present, albeit it largely concealed, component of the Soviet medical care system. In earlier times paying for medical services was widespread and indeed was commonly regarded as a necessary prerequisite for receiving care of good quality; however, such payments were generally made "under the table".

Our data indicate that about a third of the population has used private physicians or medical cooperatives at least once. The cooperatives are used with equal frequency by Groups I through IV. Approximately one quarter of the members of each of those groups reported using them at least occasionally, and the most common reason people frequent them appears to be for dental care. Only 16% of the Newly Skilled and 5.9% of the Unskilled indicated that they utilize either of these alternatives, and none of the Unskilled who use them do so on a regular basis.

By far the least frequently used alternative is a non-traditional healer. There is a wide variety of such practitioners in the medical marketplace in post-Soviet Russia. Some of them almost certainly practiced "under the table" in the past; others have entered the field of medical care quite recently. These practitioners include acupuncturists, herbalists, and osteopaths as well as hypnotists, bio-energeticists and psychic healers. Only slightly more than a 10th (11.9%) of the population reported using any of these non-traditional healers. Users are very likely to utilize a variety of other alternatives as well. This group, in other words, represents the most aggressive and active group of medical consumers. Its members are also disproportionately young, healthy and of high socioeconomic status.

In sum, the population of St. Petersburg includes one small group which generally avoids the medical care system and another which actively seeks care from a broad range of alternatives. For the most part the members of both groups are fairly young and consider themselves to be in good health. The most visible difference between them is their relative position in the status hierarchy: the non-users are disproportionately from the lowest socioeconomic groups, while those who utilize all the alternatives available in the system are disproportionately from the highest socioeconomic groups (and especially from the Established Intelligentsia). In between these two extremes lies the rest of the population, which utilizes some combination of polyclinic care and the informal assistance of friends and family who work in the medical system. For the intelligentsia the role of the latter is far more significant, while the rest of the population tends to be oriented primarily toward the formal system.

#### *Perceived changes in the medical care system since 1992*

Few people in mid 1992 expected that the medical care system would get worse. However, half of the people (22 of 44) we interviewed two and a half years later, told us that the system had in fact deteriorated further. A few went so far as to describe it as undergoing complete disintegration ("*idet razval zdravookhraneniia*"). Others responded that the system was fundamentally the same as before, but since most of them had been highly critical of the status quo, lack of change was hardly positive. Several people commented that, "the quality was poor and it hasn't got any better".

These pessimistic assessments are closely linked with very real concerns about whether the medical care system will be able to meet people's health needs. Two-thirds of the individuals we interviewed in late 1994 expressed anxiety (even fear) about the situation. Analysis of their comments reveals that these concerns are focused on those situations over which individuals sense that they have little control.

One of the most frequently mentioned worries was about the emergency care system (*skoraia pomoshch*). Historically considered one of the noteworthy achievements of Soviet medical care, much of the population has now lost faith in the emergency care system. Sudden and unexpected life-threatening illnesses or accidents are the medical problems perhaps least amenable to control. Even "connections" are of limited utility in those instances when a medical crisis demands rapid intervention with highly trained personnel and specialized medical technology.

The population of St. Petersburg now worries that ambulance crews will arrive on the scene without necessary medications or equipment, or even worse, that they will fail to arrive at all. Many individuals had heard rumors about the problem but some of our respondents were able to cite the experiences of their own acquaintances or relative: to illustrate their concerns. A member of the Established Intelligentsia cited the case of an elderly relative who had died waiting for an ambulance. A Stable Skilled respondent told a similar story: "if you call them they don't come, or they don't even accept the call. Our friend waited and waited for an ambulance. The ambulance was 30 minutes late. She died from asthma... They didn't get there in time. She was 35 years old".

A second focus of concern, one which is also shared by individuals across the socioeconomic spectrum, is the quality of hospital care. People worry primarily about shortages of medications, equipment, blood, and even food; however, for some these concerns are accompanied by apprehensions about the attitudes of hospital medical personnel. After recounting the recent hospital experience of a friend, a Newly Skilled man quipped, "their attitude is 'when you die you will free up a bed'". A woman from the Established Intelligentsia also lamented the uncaring attitudes of hospital workers but offered an explanation for them:

There is a proverb, "to be treated gratis is to be treated in vain" (*lechit'sia darom-darom lechit'sia*). That's the way things are now. It's sad when a person whose legs are paralyzed gets yelled at for not removing his tray. I witnessed such a scene in a hospital. But it's understandable. The nurse who yelled works for kopecks. They don't fire her no matter what she does, because who would take her place?

While apprehensions about hospital care are voiced by people from many different social backgrounds, the most consistent expressions of concern come from the intelligentsia. The particular foci of these concerns suggest some of the ways in which changing realities are adversely affecting the strategies which this group has long used to manage certain aspects of its medical care. The problem of acquiring medications is a case in point. This was mentioned far more often by members of the intelligentsia than by any other group. Finding "deficit" medications was always something of a problem for Soviet medical consumers. However, for much of the intelligentsia this was a problem that was soluble with the assistance of effective informal networks. In post-Soviet Russia, however, the problem of acquiring medications has changed from one of "how to find them" to "how to pay for them". Having mostly solved the former problem, the intelligentsia more than the rest of the population now seem to be experiencing a sense of relative deprivation (at least so far as getting medications is concerned).

Concerns about meeting costs have combined in the minds of some members of the intelligentsia with uncertainty about the motivations of medical personnel to create real trepidations about hospitalization. This is true even in those instances where people have confidence in their informal help networks. A member of the New Intelligentsia voiced her worries in the following way:

Suppose you suddenly need blood or medicine which they don't have. Then because of negligence or because it's a holiday or somebody simply forgets, you could die. And not because there wasn't any medicine or even because it was impossible to find. [My "connections"] could get medicines for me if we were told in time. But maybe the doctor won't even think about it. Now that's anxiety producing.

To the extent that the intelligentsia are worried about medical personnel, their concern tends to focus on treatment in hospitals. This is not to suggest that members of this group are no longer critical of polyclinic physicians. On the contrary, our respondents described them in most unflattering terms, typified by the observation of one woman from the Established Intelligentsia that, "the doctors in polyclinics are completely incompetent".

The intelligentsia, however, seem less worried than others about the quality of primary care physicians in the state medical system. This is doubtless due to the fact that members of this group remain less dependent upon polyclinic doctors. The recent difficulties experienced by the formal medical care system have had very little

impact on the strategies used by the intelligentsia to find satisfactory primary care. Polyclinic physicians may be perceived as incompetent or rude, but members of the intelligentsia tend to utilize other practitioners anyway. "I only go to our neighborhood polyclinic when I need sick leave certification", commented a member of the New Intelligentsia, "and they can treat a cold (*prostuda*). But if it's something more serious, of course, you have to get treatment from somebody else".

Other *Peterburgtsy* remain more dependent on the state medical system, and hence on polyclinic physicians, for their primary care. Not surprisingly, they express more concern about both the quality of the care they receive in that system and about the spirit in which it is delivered. Three quarters of our Skilled respondents (Groups IV and V) made negative comments about medical care providers, and their dissatisfaction focused on both the technical competence and the attitudes of physicians. Respondents described polyclinic physicians with whom they had come in contact as "rude", "insincere", "spoiled", and "inattentive".

By contrast with the intelligentsia other *Peterburgtsy* feel more dependent upon the polyclinic system. This is evident in the extent to which they describe themselves as subject to its inconsistencies, i.e. there is a widespread sense that the quality of care that one receives is beyond one's control. Comments such as, "it all depends on the individual doctor" or "it all depends on whom I end up with (*k komu popadu*)" were made repeatedly. Furthermore, it appears that those individuals who felt that they had been treated badly were less likely to seek other alternatives than to avoid medical care altogether. A Newly Skilled man stated firmly, "I don't have any confidence in them. So, I just don't go to doctors except when I need sick leave". A similar comment was made by a woman in Group IV (the Stable Skilled category), whose experiences suggest both the extent and potential consequences of the inconsistencies to which the system can be prone. This is the same woman who described having been treated by a famous oncologist (without resort to "connections"). Now, however, she avoids follow-up care at her polyclinic because she was denied the right to be treated by a physician she liked and because, in general, "I haven't sensed any great fondness for myself [among the doctors there]".

Ironically, the only individuals to express the view that the medical care system had changed for the better were also from the lowest socioeconomic groups (Group V and VI). Their numbers were small (four in all) and without exception their optimism centered on the expansion of the "pay" (*platnaia*) medical sector. For individuals without "connections" this growing sector represents in principle an alternative to the state system. Its existence, however, has not eliminated anxiety about getting medical treatment when necessary. After all, access to this new alternative requires a "fat wallet", an item which (like good "connections") is still available to only a privileged minority.

#### *Medical consumers in post-Soviet Russia: new values, old behaviors*

Almost all of the *Peterburgtsy* we interviewed told us that their overall approach to handling medical problems has not changed in recent years. Approximately one in four has had some direct experience with a "pay" medical facility, but the expansion of this new component of the medical system has not yet prompted a global reorientation of help-seeking strategies.

This apparent conservatism is not a result of principled opposition to "pay" medicine. Indeed, only three of our respondents expressed either philosophical or moral objections to that concept. Two of these were members of the Established Intelligentsia, one of whom cited Hippocrates to support his assertion that healers should not establish fees; the other lamented the immorality of a government which could allow its citizenry to become impoverished and sick without intervening. The third principled opponent of "pay" medicine, a member of the Stable Skilled, described herself as "probably just the kind of person who is used to free medical care and thinks it is humane".

Most people, however, have no objection in principle to "pay" medical care, and the great majority describe the medical system in post-Soviet St. Petersburg as offering many more possibilities than in the past. The fact that people are not exploiting those possibilities is due to the fact that very few can afford to spend much money on medical care. Concerns about costs are expressed equally by individuals from all levels of the socioeconomic hierarchy. A widespread sentiment is that there should be a two-tiered system which guarantees a basic level of

care for everyone regardless of ability to pay but permits a "pay" sector for those who have the ability and desire to use it.

Attitudes about "pay" medicine do vary somewhat by socioeconomic status, a reflection of differences in both the concrete experiences which people have had with it and more general attitudes toward medical work. For the most part the experiences reported by the intelligentsia with the "pay" sector of primary care are positive. Lower status individuals described both successes and disasters. In each case the effect seems to be to reinforce rather than challenge notions about medical help-seeking and about the motivations of physicians.

Attitudes of the intelligentsia toward "pay" medicine tend to be expressed in one or both of the following ways: first, that the quality of medical care is determined by the professionalism of the individual practitioner and is not affected by the form of payment for services; second, that paying for medical care increases the power of the consumer to demand high quality. The reports of the intelligentsia about their experiences with "pay" medicine focus on its practical advantages: convenience, accessibility, speed, and superior equipment. Although the members of this group expressed concern about the potential for charlatanism in the "pay" sector, they seem to think they can avoid it. Apparently the strategies for finding good professionals which they utilized in the Soviet era have been readily expandable to include the "pay sector". Thus, they tend not to express concern about being taken advantage of and focus instead on the efficiency with which "pay" institutions and practitioners respond to their needs.

The predominant attitude among non-intelligentsia groups toward "pay" medical practice is somewhat different. The intelligentsia focus on the intrinsic rewards of "professionalism" as providing the incentive for good work performance. Individuals without higher educations tend to focus instead on extrinsic motivations. Generalizing from their own experiences, they believe that the quality of "pay" medical care should be better because the workers are paid for their services. The comments of a Newly Skilled woman typify this perspective:

Judging by my own work, if you accept money, then of course what you do should be of high quality. When I repair a [state-owned] building I can be a little lax because nobody is paying me. [But when I am paid directly] I look carefully at each corner and every little spot on the ceiling. I think everybody has this same approach.

Good experiences with "pay" medicine reinforce this notion; however, several people reported very negative experiences. The principal effect of those seems to have been to reinforce old notions about unpredictable and uncontrollable inconsistencies, in the quality of care provided by the system. "You can buy everything now", observed a Group IV man, "but you don't always know what you're buying". In a similar vein an Unskilled woman observed, "the quality should be better, but everything is possible. You can end up with...God knows what! It's also become dangerous". The feeling that one has no control over the quality of care one receives is not new; however, when that care has been paid for with many hard-earned rubles, the frustration is far more palpable.

## CONCLUSIONS

Our analysis of developments in the Russian medical system from the perspective of ordinary consumers of medical care demonstrates continuity and change in both attitudes and behavior. It also shows the extent to which approaches to medical problems vary by socioeconomic status. *Peterburgtsy* are now particularly anxious about those aspects of medical care which they feel are beyond their control, but most seem prepared to embrace "pay" medicine so long as they can afford it and there are some minimal guarantees of quality and access. Last but not least, our examination of the medical help-seeking patterns of different socioeconomic groups suggests that the approach utilized by the intelligentsia in the past is proving reasonably adaptable to the new post-Soviet medical marketplace. For much of the rest of the population, however, finding good quality medical care remains more problematic.

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